ARKANSAS DEPARTMENT OF HEALTH
COSMETOLOGY SECTION
4815 West Markham, Slot 8
Little Rock, AR 72205
(501) 682-2168

ESTABLISHMENT CHANGE OF STATUS APPLICATION

PLEASE PRINT USING BLUE OR BLACK INK

INSTRUCTIONS: The purpose of this form is for any type of change of status to an existing establishment. **Refer to table below for required fee and instructions as to what sections of this application are required. Place an "X" in the box to indicate the type of application.**

A DUPLICATE LICENSE WILL BE MAILED OUT IN APPROXIMATLEY TWO (2) WEEKS.

FEE CALCULATION TABLE

(X)	DESCRIPTION	AMOUNT DUE	SECTIONS TO BE COMPLETED
	CHANGE NAME ONLY	**$25.00**	**SECTIONS: (A); (B); (D)**
	CHANGE OWNER ONLY	**$25.00**	**SECTIONS: (A); (C); (D)**
	CHANGE OWNER AND NAME	**$50.00**	**SECTIONS: (A); (B); (C); (D)**

SECTION (A) – ESTABLISHMENT INFORMATION CURRENTLY ON FILE WITH THE COSMETOLOGY SECTION *(PRIOR TO CHANGE)*

Establishment Name					Telephone Number ( )
Address Where Establishment Receives Mail	Suite #	City	County	State	Zip Code
Physical Address of Establishment	Suite #	City	County	State	Zip Code
Type of Establishment (CIRCLE ONE)	COSMETOLOGY MANICURE ELECTROLOGY AESTHETICS		ID NUMBER		LICENSE NUMBER
Name of Owner (Corporation or Individual)					

SECTION (B) – NEW ESTABLISHMENT NAME

NEW Establishment Name

DO NOT WRITE IN THIS AREA – FOR OFFICE USE ONLY

DATE		ID NUMBER		RECEIPT	

SECTION (C) – NEW ESTABLISHMENT OWNER

This section requires a copy of the driver's license and a legal document, bill of sale or notarized statement from previous owner to support the change of ownership.

Is the NEW owner a corporation? YES NO	If yes, name of corporation	If no, is new owner licensed? YES NO	Id number	License number

COMPLETE THE FOLLOWING INFORMATION REGARDING NEW OWNER.

Last Name	First Name (no nicknames)	Middle Name	SSN

Date of Birth	Gender (Circle One) MALE FEMALE	Race (circle one)	Black	White	Am. Indian	Hispanic	Asian	Alaskan Native

Address Where You Receive Mail	Apt #	City	County	State	Zip Code
Address Where You Live	**Apt #**	**City**	**County**	**State**	**Zip Code**

Phone ( )	**Email Address (REQUIRED)**

SECTION (D) – OWNER CERTIFICATION

In signing this application, you are certifying that:

1. The information provided on this form is correct to the best of your knowledge.
2. You are the establishment owner or are authorized to act as the owner's agent.
3. You have read this form, the laws and rules.
4. You have complied with all laws and rules governing cosmological establishments.
5. You will close your establishment if the inspector finds the establishment not in compliance with applicable rules.

Print Owner's Name	Owner's Signature	Today's Date

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DATE		**ID NUMBER**		**RECEIPT**	